GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2024

Lorenzo Cavaliere
Belmar Oakland
5990 Adams Road
Troy, MI 48098

RE: License #: AH630369651
Investigation #: 2024A1019067
Belmar Oakland

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630369651
Investigation #:	2024A1019067
Complaint Receipt Date:	09/04/2024
Investigation Initiation Date:	09/05/2024
Report Due Date:	11/04/2024
Licensee Name:	Windemere Park of Troy Operations LLC
Licensee Address:	30078 Schoenherr Rd., Suite 300 Warren, MI 48088
Licensee Telephone #:	(586) 563-1500
Authorized Representative:	Lorenzo Cavaliere
Administrator:	Kathleen Walker
Name of Facility:	Belmar Oakland
Facility Address:	5990 Adams Road Troy, MI 48098
Facility Telephone #:	(248) 602-2400
Original Issuance Date:	05/02/2016
License Status:	REGULAR
Effective Date:	11/02/2023
Expiration Date:	11/01/2024
Capacity:	69
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly admitted to the facility.	Yes
Resident A was improperly supervised.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/04/2024	Special Investigation Intake 2024A1019067
09/05/2024	Special Investigation Initiated - Face to Face Conducted onsite inspection.
09/05/2024	Inspection Completed On-site
09/05/2024	Inspection Completed-BCAL Sub. Compliance
09/06/2024	APS Referral Notified APS of the allegations.

ALLEGATION:

Resident A was improperly admitted to the facility.

INVESTIGATION:

On 9/4/24, the department received a complaint alleging that Resident A does not have guardianship in place, is at the facility against his will and staff should never have allowed him to be admitted. The complaint alleged that upon admission, Resident A was confused and combative, and staff had to call the police. It is alleged that when the police responded they informed staff that they had no right to keep Resident A at the facility because they did not have proper guardianship papers. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 9/5/24, I conducted an onsite inspection. I interviewed Employees 1, 2, and 3 at the facility. All three staff reported that Resident A was admitted to the facility's memory care unit on 8/30/24 after being transferred from a local hospital. Employees 1, 2 and 3 acknowledged that Resident A has verbalized he does not want to reside at the facility but that they are aware he legally can make his own decisions. Employees 1, 2 and 3 reported that Relative A signed the admission contract on behalf of Resident A. Employee 3 reported that she was advised by the facility's management company, Symphony Network, to admit the resident despite not having guardianship in place. Employee 3 reported that Relative A has petitioned for guardianship over Resident A, however that court hearing is not scheduled until sometime in October.

While onsite, I reviewed Resident A's admission contract and observed that it was signed by Relative A; Resident A's signature was not located on the document. Employee 3 also provided evidence of a "petition for guardianship", dated 8/22/24.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.
ANALYSIS:	Resident A's admission contract does not contain the proper signatory. The licensee knowingly admitted Resident A to the facility and allowed Relative A to sign the contract on his behalf without having the legal authority, such as guardianship or an enacted power of attorney.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

ALLEGATION:

INVESTIGATION:

On 9/5/24, additional information was submitted to the department via the intake unit that alleged that Resident A is not receiving proper supervision. The complaint alleged that Resident A eloped from the facility by jumping out a second-floor window. Due to the anonymous nature of the complaint, additional information could not be obtained.

Employees 1 and 2 reported that the previous evening, Resident A was able to successfully jump out of a second-floor window of the facility's memory care unit.

Employees 1 and 2 reported that police were called, and Resident A was eventually found unharmed. Employees 1 and 2 reported that emergency medical services were called, however Resident A refused to go to the hospital. While onsite, Employee 1 provided an incident report that read:

> *[Resident A] went into another resident room and jumped out the window. He told me he wanted to get some fresh air, and he needed to help someone outside. Noting was wrong with [Resident A] when he came back. He refused to go to the hospital and the ambulance checked him and said he seems fine.*

In follow up correspondence, Employee 2 provided additional documentation that read:

> *6:33pm notified [Employee 1] from [Employee 4] that res is missing (other res reported to [Employee 4] that res popped out screen & went out window). 6:35 [Employee 1] notified [Employee 2] to assist with search, [Employee 4] called 911], [Employee 1] notified [Relative A] approx. 6:38pm. Staff completed headcount internally to verify all res and staff present. [Resident A] was located by [Employee 1/Employee 2] at 7:33pm about one block away. 911 was called again to assess for injuries. Vitals taken & resident req to return to facility. MD notified for visit to look into potential hallucinations since resident reported "people chasing him". MD visit scheduled 9/5/24 @ 2pm. Resident reported he feels fine, no injury & did not want further treatment. 15 min checks in place without any concern. Res stated "wont do that again- I love it here". Maintenance dept came 9/5/24 to verify all locks on windows are functional & in place. Wife guardianship court date confirmed, 10-3-24. MD ordered new medication, family visited & reported resident in good spirits, staff easily able to call for him. Will continue to watch for any changes in condition.*

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference R 325.1901	**(1) (p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while**

	under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision. **(u) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: (iv) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Resident A lacked sufficient supervision, as evidenced by his ability to exit the facility out of a second story window of the memory care unit. He was outside unattended for roughly an hour, placing him at significant risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Resident A was admitted to the facility on 8/30/24, however at the time of my onsite inspection on 9/5/24, he did not have a service plan in place. Employee 1 reported that he was admitted without a service plan and confirmed one still needed to be written.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.
ANALYSIS:	Resident A’s service plan was not developed in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license.

09/11/2024

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/30/2024

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section